

		FOR OFF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0037044</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																																																																																							
<b>Facility Name:</b> <u>Lincoln Square</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																																																							
<b>Address:</b> <u>202 South Main Street</u> <u>Jonesboro</u> <u>62952</u>																																																																																									
<div>NumberCityZip Code</div>																																																																																									
<b>County:</b> <u>Union</u>																																																																																									
<b>Telephone Number:</b> <u>618 833-2063</u> <b>Fax #</b> <u>618 833-4993</u>																																																																																									
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Facility Name & ID Number Lincoln Square

# 0037044 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 5475

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>15</u>	ICF/DD 16 or Less	<u>15</u>	<u>5,475</u>	6
7	<u>15</u>	TOTALS	<u>15</u>	<u>5,475</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,201</u>			<u>5,201</u>	13
14	TOTALS	<u>5,201</u>			<u>5,201</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by the Department?

26 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/05 Fiscal Year: 12/31/05

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      Lincoln Square      #      0037044      Report Period Beginning:      1/1/05      Ending:      12/31/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	25,002	2,218	1,142	28,362		28,362		28,362			1
2	Food Purchase		42,301		42,301		42,301	(434)	41,867			2
3	Housekeeping	989	4,311	800	6,100		6,100	73	6,173			3
4	Laundry		429		429		429		429			4
5	Heat and Other Utilities			11,429	11,429		11,429	180	11,609			5
6	Maintenance		2,022	1,757	3,779		3,779	4,769	8,548			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	25,991	51,281	15,128	92,400		92,400	4,588	96,988			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	164,192	2,660	3,533	170,385		170,385	887	171,272			10
10a	Therapy		541	4,966	5,507		5,507		5,507			10a
11	Activities	15,613		295	15,908		15,908		15,908			11
12	Social Services		842	3,553	4,395		4,395	(677)	3,718			12
13	CNA Training	3,557		1,856	5,413		5,413		5,413			13
14	Program Transportation		1,844	2,777	4,621		4,621	279	4,900			14
15	Other (specify):* <b>Day Training</b>			186,918	186,918		186,918	(186,918)				15
16	<b>TOTAL Health Care and Programs</b>	183,362	5,887	207,498	396,747		396,747	(186,429)	210,318			16
	<b>C. General Administration</b>											
17	Administrative			5,903	5,903		5,903	4,349	10,252			17
18	Directors Fees							130	130			18
19	Professional Services			26,582	26,582		26,582	(23,759)	2,823			19
20	Dues, Fees, Subscriptions & Promotions			8,624	8,624		8,624	(6,819)	1,805			20
21	Clerical & General Office Expenses	5,235	3,967	4,714	13,916		13,916	7,876	21,792			21
22	Employee Benefits & Payroll Taxes			33,618	33,618		33,618	4,148	37,766			22
23	Inservice Training & Education			54	54		54		54			23
24	Travel and Seminar			61	61		61	5	66			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,973	1,973		1,973	157	2,130			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	5,235	3,967	81,529	90,731		90,731	(13,913)	76,818			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	214,588	61,135	304,155	579,878		579,878	(195,754)	384,124			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			5,484	5,484		5,484	10,396	15,880			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			327	327		327	1,218	1,545			32
33	Real Estate Taxes			8,064	8,064		8,064	126	8,190			33
34	Rent-Facility & Grounds			42,000	42,000		42,000	(41,521)	479			34
35	Rent-Equipment & Vehicles			90	90		90	205	295			35
36	Other (specify):* See Pg. 24			2,092	2,092		2,092	(2,092)				36
37	TOTAL Ownership			58,057	58,057		58,057	(31,668)	26,389			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,440	30,440		30,440		30,440			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			30,440	30,440		30,440		30,440			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	214,588	61,135	392,652	668,375		668,375	(227,422)	440,953			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (186,918)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(337)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,653	30		9
10	Interest and Other Investment Income	(258)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,500)	20		18
19	Entertainment				19
20	Contributions	(150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(885)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,207)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(1,351)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (188,953)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(38,469)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,469)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (227,422)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lincoln Square

ID#0037044

Report Period Beginning:1/1/05

Ending:12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Floral	\$ (173)	121
2	Clothing	(504)	122
3	PAC Dues	(72)	203
4	Advertising	(118)	204
5	Vending Expenses	(434)	25
6	Chamber Dues	(50)	206
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(1,351)	49

## Summary A

**12/31/05**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

## Summary B

12/31/05

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacob L. Alley	50	Mulberry manor	Anna	JR's Centre	Anna	Workshop
Diana Alley	50	Holly Hill	Anna	kel-Tech Mgmt Co.	Anna	Acct/Mgmt
		Glen Brook	Vienna	ILS, Inc.	Anna	CILA
		Pilot House	Cairo	J & J Partners	Anna	Land Trust
		Krypton	Metropolis	ILS Land Trust	Anna	Land Trust
		Liberty House	Marion			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 73	\$ 73	1
2	V	5	Utilities		kel-Tech Management Co.	25.00%	180	180	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	186	186	3
4	V	14	Transportation		kel-Tech Management Co.	25.00%	279	279	4
5	V	18	Director's Fees		kel-Tech Management Co.	25.00%	130	130	5
6	V	19	Professional Services		kel-Tech Management Co.	25.00%	241	241	6
7	V	20	Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	71	71	7
8	V	21	Office Expenses		kel-Tech Management Co.	25.00%	1,233	1,233	8
9	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	4,485	4,485	9
10	V	24	Seminar		kel-Tech Management Co.	25.00%	5	5	10
11	V	26	P & C Insurance		kel-Tech Management Co.	25.00%	157	157	11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	126	126	12
13	V	34	Building Lease		kel-Tech Management Co.	25.00%	479	479	13
14	Total			\$			\$ 7,645	\$ * 7,645	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Lease	\$	kel-Tech Management Co.	25.00%	\$ 205	\$ 205	15
16	V	10	Nursing		kel-Tech Management Co.	25.00%	887	887	16
17	V	17	Administration		kel-Tech Management Co.	25.00%	4,349	4,349	17
18	V	21	Clerical		kel-Tech Management Co.	25.00%	6,643	6,643	18
19	V	6	Maintenance		kel-Tech Management Co.	25.00%	3,566	3,566	19
20	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	20
21	V	34	Building Lease	36,000	Lincoln Square Land Trust	100.00%		(36,000)	21
22	V	30	Depreciation		kel-Tech Management Co.	25.00%	902	902	22
23	V	30	Depreciation Office		Lincoln Square Land Trust	100.00%	841	841	23
24	V	32	Interest Expense Office		Lincoln Square Land Trust	100.00%	1,476	1,476	24
25	V	34	Office Rent	2,500	Lincoln Square Land Trust	100.00%		(2,500)	25
26	V	6	Repairs Office		Lincoln Square Land Trust	100.00%	1,017	1,017	26
27	V	34	Diana Office Rent	3,500	Diana Alley Office Rent	100.00%		(3,500)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 66,000			\$ 19,886	\$ * (46,114)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Diana Alley	DON/Owner		50.00	28,229	8	20.00	Nursing	\$ 24,030	10-1	1
2	Jacob Alley	Owner		50.00							2
3											3
4											4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation										7
8	Diana alley							Nursing	887	10-1	8
9	Jacob Alley							Maintenance	3,566	6-1	9
10	James A. Keller							Admin	4,349	17-1	10
11											11
12											12
13								TOTAL	\$ 32,832		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization kel-Tech Management Co.  
Street Address 158 E. Vienna Street  
City / State / Zip Code Anna, IL 62906  
Phone Number ( 618 833-5070  
Fax Number ( 618 833-4993

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contributin	360,999	12	\$ 1,100	\$	24,000	\$ 73	1
2	5	UTILITIES ELECT/GAS	Mgmt Fee Contributin	360,999	12	2,401		24,000	160	2
3	5	UTILITIES WATER-B	Mgmt Fee Contributin	360,999	12	309		24,000	21	3
4	6	GROUNDS MAINT	Mgmt Fee Contributin	360,999	12	416		24,000	28	4
5	6	MAINTENANCE SUPPLIES	Mgmt Fee Contributin	360,999	12	245		24,000	16	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contributin	360,999	12	119		24,000	8	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contributin	360,999	12	99		24,000	7	7
8	6	REPAIRS BLDG	Mgmt Fee Contributin	360,999	12	90		24,000	6	8
9	6	REPAIRS FURN/EQUIP	Mgmt Fee Contributin	360,999	12	1,830		24,000	122	9
10	14	REPAIRS VEHICLES	Mgmt Fee Contributin	360,999	12	246		24,000	16	10
11	14	TRANSPORTATION	Mgmt Fee Contributin	360,999	12	3,953		24,000	263	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contributin	360,999	12	1,950		24,000	130	12
13	19	LEGAL & ACCOUNTING	Mgmt Fee Contributin	360,999	12	3,625		24,000	241	13
14	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contributin	360,999	12	1,061		24,000	71	14
15	21	EDUCATIONAL SUPPLIES	Mgmt Fee Contributin	360,999	12	45		24,000	3	15
16	21	BANK CHARGES	Mgmt Fee Contributin	360,999	12	64		24,000	4	16
17	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contributin	360,999	12	243		24,000	16	17
18	21	COPIER EXPENSE SERVICE C.	Mgmt Fee Contributin	360,999	12	475		24,000	32	18
19	21	G & A MISC	Mgmt Fee Contributin	360,999	12	484		24,000	32	19
20	21	SUPPLIES STOCK	Mgmt Fee Contributin	360,999	12	793		24,000	53	20
21	21	G & A SUPPLIES	Mgmt Fee Contributin	360,999	12	9,132		24,000	607	21
22	21	POSTAGE	Mgmt Fee Contributin	360,999	12	2,525		24,000	168	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contributin	360,999	12	825		24,000	55	23
24	21	TELEPHONE	Mgmt Fee Contributin	360,999	12	2,400		24,000	160	24
25	TOTALS					\$ 34,429	\$		\$ 2,292	25

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization kel-Tech Management Co.  
Street Address 158 E. Vienna Street  
City / State / Zip Code Anna, IL 62906  
Phone Number ( 618 833-5070  
Fax Number ( 618 833-4993

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CELL PHONE EXPENSE	Mgmt Fee Contributin	360,999	12	\$ 1,159	\$	24,000	\$ 77	1
2	21	UTILITIES-INTERNET	Mgmt Fee Contributin	360,999	12	408		24,000	27	2
3	22	INS EMP GROUP	Mgmt Fee Contributin	360,999	12	43,812		24,000	2,913	3
4	22	INSURANCE W/C	Mgmt Fee Contributin	360,999	12	3,770		24,000	251	4
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contributin	360,999	12	19,880		24,000	1,322	5
6	24	ADM. STAFF TRAINING	Mgmt Fee Contributin	360,999	12	79		24,000	5	6
7	26	INSURANCE BLDG & LIAB	Mgmt Fee Contributin	360,999	12	1,123		24,000	75	7
8	26	INSURANCE VEHICLES	Mgmt Fee Contributin	360,999	12	1,245		24,000	83	8
9	33	REAL ESTATE TAXES	Mgmt Fee Contributin	360,999	12	1,893		24,000	126	9
10	34	LEASE BLDG	Mgmt Fee Contributin	360,999	12	7,200		24,000	479	10
11	35	LEASE EQUIP	Mgmt Fee Contributin	360,999	12	3,076		24,000	205	11
12	10	NURSING WAGES	Mgmt Fee Contributin	360,999	12	13,341	13,341	24,000	887	12
13	17	ADMINISTRATION WAGES	Mgmt Fee Contributin	360,999	12	65,419	65,419	24,000	4,349	13
14	21	CELRICAL WAGES	Mgmt Fee Contributin	360,999	12	99,921	99,921	24,000	6,643	14
15	6	MAINTENANCE WAGES	Mgmt Fee Contributin	360,999	12	53,640	53,640	24,000	3,566	15
16	30	DEPRECIATION	Mgmt Fee Contributin	360,999	12	13,569		24,000	902	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 329,536	\$ 232,321		\$ 21,910	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	US Bank		X	Vehicle Loan	\$296.45	6/2/04	\$ 9,909	\$ 4,864	6/2/07	4.9000	\$ 327	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$296.45		\$ 9,909	\$ 4,864			\$ 327	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,909	\$ 4,864			\$ 327	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ noneLine #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.  
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000	5,029	8
2001	5,156	9
2002	5,218	10
2003	5,317	11
2004	6,624	12

Sch IX, Line 7	8064	
kel-Tech Allocation	126	
Sch. V, Line 33, col. 8	8190	

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lincoln Square COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037044

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE 618 833-5070 FAX #: 618 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-00-07-353</u>	<u>Lot 69 Grammer's Addition</u>	\$ <u>5,724.54</u>	\$ <u>5,724.54</u>
2. <u>14-00-07-418</u>	<u>W 1/2 Lot 120 Grammer's Addition</u>	\$ <u>839.84</u>	\$ <u>839.84</u>
3. <u>14-00-07-408</u>	<u>Lot 111 Grammer's Addition</u>	\$ <u>59.74</u>	\$ <u>59.74</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>6,624.12</u>	\$ <u>6,624.12</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES X \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,200

B. General Construction Type: Exterior Wood Frame Wood

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1		2		3		4	
	Use		Square Feet		Year Acquired		Cost	
	1	Healthcare	8,000		1987		\$ 7,800	
	2							
	3	TOTALS	8,000				\$ 7,800	

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	15		2005	1987	\$ 113,400	\$	27.5	\$ 3,952	\$ 3,952	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Carpeting			1997	4,056		7	271	271	4,056	9	
10	Living Room Carpet			1998	571		7	57	57	571	10	
11	Carpeting			2001	3,640		7	520	520	3,640	11	
12	Tile Floor			2002	3,922	211	15	261	50	2,021	12	
13	Fire Alarm Panel			2005	1,835	262	5	262		262	13	
14	Wood Decking			2005	2,100	300	15	300		300	14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$129,524	\$773		\$5,623	\$4,850	\$10,850		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,745	\$101	\$174	\$73	7	\$1,745	71
72	Current Year Purchases	4,577	2,766	368	(2,398)	7	2,766	72
73	Fully Depreciated Assets	64,688		2,365	2,365	7	64,688	73
74								74
75	TOTALS	\$71,010	\$2,867	\$2,907	\$40		\$69,199	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Ford Van	2000	\$26,232	\$468	\$2,625	\$2,157	5	\$26,232	76
77	Healthcare	Ford Van	2004	14,909	1,376	2,982	1,606	5	11,986	77
78										78
79										79
80	TOTALS			\$41,141	\$1,844	\$5,607	\$3,763		\$38,218	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$249,475	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$5,484	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$14,137	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,653	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$118,267	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related Party
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐YES☐NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease.
- 

9. Option to Buy:
- ☐YES☐NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐YES☒NO
16. Rental Amount for movable equipment: \$90
- Description:Water Cooler Rental

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

86

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	308	898		1,206
4	Clinical Wages (b)	601	1,751		2,352
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	910	945		1,855
8	CNA Competency Tests				
9	TOTALS	\$ 1,819	\$ 3,594	\$	\$ 5,413
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,413			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	8

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$58,082	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	72,883		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	70,315		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$201,280	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	16,124		15
16	Equipment, at Historical Cost	112,151		16
17	Accumulated Depreciation (book methods)	(118,264)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$10,011	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$211,291	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$7,844	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,622		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,717		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$25,983	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,864		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$14,864	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$40,847	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$170,444	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$211,291	\$	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 229,348	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 229,348	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,117	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(70,021)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (58,904)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 170,444	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 487,108	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 487,108	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	186,918	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 186,918	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,505	11
12	Gift and Coffee Shop	1,703	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,208	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	258	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 258	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 679,492	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	92,400	31
32	Health Care	396,747	32
33	General Administration	90,731	33
	<b>B. Capital Expense</b>		
34	Ownership	58,057	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	30,440	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 668,375	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	11,117	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 11,117	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	416	416	\$ 24,030	\$ 57.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,996	2,012	15,613	7.76	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,327	2,472	25,002	10.11	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	141	141	989	7.01	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	710	710	5,235	7.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,042	2,082	32,560	15.64	29
30	Habilitation Aides (DD Homes)	12,070	12,458	111,159	8.92	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,702	20,291	\$ 214,588 *	\$ 10.58	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	26	\$ 1,107	1	35
36	Medical Director	36	3,600	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	55	1,318	10	38
39	Pharmacist Consultant	10	300	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	34	2,055	10a	43
44	Activity Consultant				44
45	Social Service Consultant	101	3,552	12	45
46	Other(specify) ADM Consultant	59	5,903	17	46
47	Dental Consultant	12	1,200	10	47
48	Psychologist/Psychiatrist	42	2,911	10a	48
49	TOTAL (lines 35 - 48)	375	\$ 21,946		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
			\$	Workers' Compensation Insurance		\$ 3,245	IDPH License Fee		\$		
				Unemployment Compensation Insurance		9,686	Advertising: Employee Recruitment		103		
				FICA Taxes		16,196	Health Care Worker Background Check				
				Employee Health Insurance		3,429	(Indicate # of checks performed 13 )		212		
				Employee Meals		337					
				Illinois Municipal Retirement Fund (IMRF)*			See Pg. 24		1,419		
				Employee Physicals		725	kel-Tech Allocation		71		
				kel-Tech Allocation		4,485					
				Less Staff Meals		(337)					
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)											
B. Administrative - Other											
Description			Amount				Less: Public Relations Expense		( )		
Cheryl Sherrill, Adm. Consultant			\$ 5,903				Non-allowable advertising		( )		
							Yellow page advertising		( )		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 5,903	TOTAL (agree to Schedule V, line 22, col.8)		\$ 37,766	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,805		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
C. Professional Services				Description		Line #	Description		Amount		
Vendor/Payee	Type		Amount				Out-of-State Travel		\$		
kel-Tech Management Co	Accting/Mgmt Services		\$ 24,000								
Barnett & Levine	CPA Services		1,635								
FMGR	Legal Services		72				In-State Travel				
Verdetta Modicue	Legal Services		875								
							Seminar Expense				
							Seminar Expense		61		
							kel-Tech Allocation		5		
							Entertainment Expense		( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL		\$ 66		

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

**(See instructions.)**

[illegible]

Facility Name &amp; ID Number Lincoln Square

# 0037044

Report Period Beginning:

1/1/05

Ending:

12/31/05

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. II Healthcare Assoc. \$828
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Lincoln Square #0032469 1/6/88
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,440  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 337 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not required of this facility.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Lincoln Square, Inc.  
Sch. XIX, F.  
2005

Resident Bond Renewal	\$ 240
IHCA Dues	828
PAC Dues	72
Corp. Annual Report	130
Other Fees	77
Subscriptions	144
IDPH Fines	6,500
Donations	150
Chamber Dues	50
Advertising	118

Less Non-Allowables:	
PAC Dues	(72)
IDPH Fine	(6,500)
Donations	(150)
Chamber Dues	(50)
Advertising	(118)
Total	<u>\$ 1,419</u>

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Lincoln Square, Inc.  
Sch. V, line 36, Col. 4  
2005

Bad Debt	\$ 885
Income Taxes	<u>1,207</u>
	<u>\$ 2,092</u>

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Lincoln Square, Inc.  
Reconciliation of Sch XI to Sch V, Line 30, Col. 8  
2005

Sch XI, Line 83	\$ 14,137
kel-Tech Management Allocation	902
Office Depreciation	<u>841</u>
Sch V, Line 30, Col. 8	<u>\$ 15,880</u>

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Lincoln Square, Inc.  
Reconciliation of Book and Tax Income  
2005

Adjusted book income	\$ 11,116
Adjustment for accrual changes	
from 1/1/05 to 12/31/05	46,774
Adjustment for non-deductable	
expenses:	
Penalties (Refund)	<u>(335)</u>
Taxable income per Federal Return	<u>\$ 57,535</u>

Related Parties Schedule VII  
Owners Compensation  
Jan 1, 2005 - Dec 31, 2005

Totals / Entity		Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 134,362	11,964	11,077	22,000			6,000			43,279		40,042
Denise Pippins	\$ 87,416	25,964	21,058	40,394								
Diana Alley	\$ 103,421	11,964	28,221	9,600	15,300			24,030	13,341			965
Jo Ann Keller	\$ 140,988			14,923	102,000	24,065						
James K. Keller	\$ 29,323			14,923	14,400							
Jacob Alley	\$ 50,613								50,613			
Jake Alley	\$ 39,594		36,994		2,600							
James A. Keller	\$ 97,265		20,493						65,419		11,353	
\$ 682,982		\$ 49,892	\$ 117,843	\$ 101,840	\$ 134,300	\$ 24,065	\$ 6,000	\$ 24,030	\$ 129,373	\$ 43,279	\$ 11,353	\$ 41,007